FAMILY AND MEDICAL LEAVE CERTIFICATION FORM
PERSONAL SERIOUS HEALTH CONDITION

For Completion by the EMPLOYER

Employer name and contact _____

For Completion by the EMPLOYEE

Your name:

_____

First Middle Last

_____

Employee Signature Date

For Completion by the HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA to care for his/her own serious health condition. Answer, fully and completely, all questions below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs care. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

Does the above-named employee have a serious health condition? ____Yes ____No
(A **serious health condition** is a disabling physical or mental illness, injury, impairment or condition involving either inpatient care in a hospital, or outpatient care that requires continuing treatment or supervision by a health care provider.)

Approximate date condition commenced: _____

Probable duration of condition: _____

Please provide a brief statement of the course of treatment prescribed by you, including an estimate of the number of office visits, and the nature, frequency and duration of treatment (diagnosis not required):

_____
_____
_____
_____
_____
_____.

Is inpatient hospitalization is required? _____Yes _____No

Is the patient named above unable to perform the duties of his/her position?
_____Yes _____No

If "yes," please describe the extent to which the patient is unable to perform the duties of his/her position:

_____
_____
_____
_____
_____

_____ _____

Signature of Health Care Provider **Date**